STATEMENT

of

Vietnam Veterans of America

Presented by

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Director, Government Relations

Before the
House Committee on Veterans' Affairs
Subcommittee on Health

Regarding

Public Law 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002

March 27, 2003

Vietnam Veterans of America

P.L. 107-287 the Department of Veterans Affairs Emergency Preparedness Act of 2002
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Mr. Chairman, and member of the Subcommittee on Health, on behalf of Vietnam Veterans of America (VVA), and our National President Thomas H. Corey, I thank you and your distinguished colleagues for the opportunity to testify before you regarding P.L. 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002.

Emergency Preparedness for Bio-Terrorism

Since the war on terrorism became a major focus of our National consciousness in the wake of the attacks of September 11, 2001, VVA has testified repeatedly on the need for the Department of Veterans Affairs (VA) to be properly prepared to meet the obligations of the VA's "Fourth Mission," and be prepared to handle mass casualty contingencies, particularly those involving weapons of mass destruction (WMD). This concern was widely shared by Members of this Committee. In response to the clear need, Public Law 107-287 was enacted on November 7, 2002. This was a significant statement by the Congress of the need to take explicit action to be able to properly fulfill the mandate of the so-called "Fourth Mission" of the VA.

However, when Congress funded the VA for the current fiscal year, FY 2003, no funds were provided for the four national emergency preparedness centers. In fact funds appropriated were expressly forbidden to be spent on the emergency preparedness centers. This makes it very difficult, to say the least, to create an educational curriculum for medical students and professionals to recognize and properly treat the wounds due to Weapons of Mass Destruction (WMD) as mandated by the Public Law 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002. VVA asks for you strong backing of our request that $20 million be included in VA FY04 Appropriation legislation to establish these centers as mandated by law, as these centers are critical to the Fourth Mission of the VA.

VVA understands, but respectfully disagrees with the contention of the leadership of the Subcommittee on VA, HUD, and Independent Agencies of the House Committee on Appropriations that VA should be precluded from spending funds that otherwise would go for veterans health care for this purpose.

While VVA would agree that ideally the Bioterrorism bill under the jurisdiction of the House Commerce Committee, or from appropriations for the Department of Homeland Security and/or the Department of Health & Human Services should transfer significant funds to VA for the purpose of the Fourth Mission, this appears to be unlikely in the near term.

It is worth noting that shortly after the 911 attacks, Congress gave the President $20 Billion in unfettered, and as we understand it, non-year specific money for the general purpose of "homeland security." Of these funds VA only asked for $77 million for preparation to meet the

vital "Fourth Mission" of the VA, and never even received close to that paltry (in the face of the huge mission) sum of money. VVA believes that a good part of this $20 Billion went to other agencies and departments for purposes that the ordinary taxpayer would hardly consider to be related to defending our Nation here at home.

Frankly, the health of the civilian population in the wake of any potential attack should be a major concern of the President and his Administration. However, unless we missed it, this Administration has not sought any such funds to build the needed organizational capacity at the VA medical facilities. If the President asked for such funds, it would be available, no matter what the amount requested, by the end of next week if that is when he said he needed the funds. We are at war, yet too much seems to be proceeding on a business as usual basis in too many areas of potential real vulnerabilities.

While we believe that the House Subcommittee on VA-HUD Appropriations are correct that it is vital to the American people these centers to move forward. One good way to solve this dispute would be to properly fund VA health care by enacting legislation that would create mandatory funding that would provide the full funding of $35 billion that the veterans health care system should have this year, had funding kept pace with inflation and per capita increases since 1996. You will note that there is a graph visually portraying this fact in Appendixes I-II of this statement. There is further elucidation of the problems with funding in the VVA 2003 Legislative Priorities testimony before this Committee on March 20, 2003, which is posted on this Committees' web site.

Insufficient Infrastructure

The VA health care centers today do not have sufficient infrastructure to properly meet the demands of major attacks on the United States. While there have been some nascent efforts toward training VA staff in how to recognize and deal with possible modes of terrorist attacks, VVA would point out that we cannot even get VA to take a proper military history for veterans seeking medical services, which should be the common sense first step in a system ostensibly geared toward identifying, addressing, and properly treating the wounds of war.

VVA was informed by VA Environmental Hazards & Public Health staff at the Veterans Health Administration that there is no expert in treating biological or chemical warfare agents at each of the VA medical centers around the country, not even in an "on call" or consultant capacity. We are also given to understand that there is no ongoing effort to train staff physicians in how to treat these types of WMD wounds, much less the part time physicians and the residents and interns who form much of the overall medical capacity of the VA. Even more disturbing is the surprise that greets questions about why this is not being done.

It should be no secret to any Member on this distinguished panel, nor anyone in attendance, that VA cannot take care of the veterans who are seeking services now, in most sections of the country. VA medical center inpatient capacity has been most dramatically reduced, to far less than half of the capacity at the end of the first Gulf War in 1991. The veterans healthcare system is so overwhelmed and so short of vitally needed resources that Secretary Principi has been forced into doing triage by means of taking the extraordinary step of temporarily suspending new enrollments by what are now called "Category 8" veterans until such time as there is enough money provided to hire enough staff to care for all veterans in need of health care services. In 1996, VA had significantly more inpatient beds (meaning not only the physical beds, but more importantly the trained medical professionals that comprise the teams to serve patients in those beds), than today. You only have to look at the graphs in Appendixes III-IV to realize that nursing and doctor staff are not there to meet all of the demands now, never mind the returning troops who may be in such need and the civilians who may be wounded or ill as a result of terrorist attacks in the United States.

In light of all of the above, VVA top leaders and key staff were puzzled at the assertion by Deputy Secretary of Veterans Affairs McKay in the Washington Post (3/25/03) that VA will make as many as 7,000 beds available to the Department of Defense for returning service personnel who are wounded and cannot be seen by overloaded military medical facilities. VVA is certainly interested in exactly where these beds are located, given the dramatic reductions in force and degrading of organizational capacity of the Veterans Health Administration (VHA) during the past decade.

Veterans Health Initiative (VHI)

Veterans Health Initiative (VHI) was started in 1999 to accomplish two primary goals, each of which had specific objectives. The Task Force was initiated and named by Dr. Thomas Garthwaite, then Undersecretary of Veterans for Health. There was a task group that was supposed to come up with recommendations and actual curricula about the primary special wounds and illnesses due to the very dangerous occupation that all veterans were engaged in at one time, whether it was two years or twenty five years. Additionally this group was supposed to cooperate with the other subgroup and develop a plan and short curriculum for all VA staff who are veterans, and what is special about veterans health care as opposed to general health care that happens to be for veterans. That second subgroup, Co-Chaired by Dr. Arthur Shelton (Col, USA-Retired) and Dr. Alfonse Batres, was supposed to guide creation of an appropriate military history for each veteran that comes to the VA for health care. That subgroup included representatives from The American Legion, Vietnam Veterans of America (VVA), and from the Department of Defense (DoD) as well as VA employees

The curricula that were produced are the first ever of this kind, and may be viewed at www.va.gov/vhi. While VVA would like to see improvements in a number of the curricula, the mere fact that they exist is a very positive step. However, very few at VA know of the existence of these curricula. While the original discussion was for financial incentives provided to those who studied the curricula and passed a rigorous competency based exam, rewarding staff with the "coin of the realm" has gone by the wayside. Now one may use the curricula for continuing education credits only. The "exam" has a 100% pass rate.

Much of the work to create a complete military history as a mandatory screen on the automated patient treatment record (PTR) at VHA was done. The goals were to produce a seamless transition of military records and military medical records to a VA computer repository as well as to the Records Center at St. Louis when a person separates from the military. Additionally, there would be a complete military history taken for those already separated from the military.

There was much discussion and general agreement of an additional need to train all clinical staff as to the importance of the military history, testing for illnesses, injuries, maladies, and other conditions (e.g., parasites that can lay dormant for up to fifty years) that veterans might have been potentially exposed to in military service depending on branch, dates of service, duty stations, military occupation, and what actually happened to the former service member. Lastly, there was general assent to the need for training for all VA staff, including clerical and housekeeping as to who are veterans, and what is the mission of the VA. There was even a training film potentially designated for use in such a broad scale effort to move VA toward its central mission of being an effective veterans health care system.

All of these efforts slowed when the Senate forced a dilution in the requirement to take a complete military history from a mandate to a "sense of the Congress." After Dr. Garthwaite left all visible efforts to move ahead with taking a military history virtually ceased. Even the proposed training film was lost for several months, and by the time it was located (in response to persistent inquiries from VVA) the soundtrack had changed and certain copyright permissions had been allowed to expire.

VVA urges this Committee and your distinguished counterparts on the Senate side to require that VA create such a mandatory military screen as an integral part of the PTR and have it fully operational within the year. (The beta testing of a preliminary version of the system was done last year.) We also strongly urge that the Congress require that the capability to do nationwide searches regularly based on disease, condition, or duty station be an integral part of this system. If VA says that this cannot be done, then get some manager in there who will get it done. Suspending all step promotions and bonuses and promotions until it go done would mean design and full implementation in weeks or a few short months instead of years. With this capability,

VA could easily be able to discern patterns related to particular duties, particular location, or other variables that would provide clues as to fruitful avenues and areas needing focused research. It can be done in short order with the proper will to do it.

Pre-Deployment & Post-Deployment Physicals

Although required by law to take pre-deployment physicals for all troops prior to deployment, including blood samples to be preserved, and a complete psycho-social examination the Department of Defense (DoD) has deliberately failed to obey the law. The law, a copy of which is attached to this statement as Appendix V, is very clear on what is required. VVA points out that this is the law, and not a suggestion. All of the people involved at DoD took the public officers oath, wherein they swore to uphold the laws of the United States of America. It would seem to a layman that these individuals, by ignoring the law, have violated their oath of public office. At some point this treating of laws by some elements of the Federal bureaucracy as cute ideas advanced by the Congress must be brought to account. This is true at both the VA as well as DoD.

The Assistant Secretary of Defense for Health Affairs and the Deployment Force Safety Directorate have simply not done what is required by the law, and which common sense would dictate in light of the experiences of the past. Instead of fulfilling the intent of the law and ensuring that a "baseline" for every deployed service member is taken, great effort seems to be expended on trying to convince the media and the Congress that laughable questionnaires utterly useless from a scientific epidemiological viewpoint is somehow meeting the clear mandates of the law. This reminds one of the F. Scott Fitzgerald quote, "Let's not and say we did!"

Said another way, as one VVA leader put it, "If these people had spent as much time and effort on medical work that would be useful in the future as they have on courting the press and "SPIN" efforts, then our troops would be in good hands." Unfortunately that does not appear to be the case.

This is not a new issue, as VVA and others have been attempting to get these physicals and blood samples taken properly for more than a year for those military personnel deployed into harms way. We even spoke directly to Secretary of Defense Rumsfeld in May of 2002. An assistant to Dr. Winkenwerder who was present noted that it was a big job, as the force was large. The response from VVA was that we understand that it is a large force, but that is their job. Does the fact that it is a large force mean that they will not be able to get sufficient ammunition to all of our forces when they need it?

While one must be careful of drawing parallels too easily, it is at least worth noting that this office that failed to ensure the required creation of a medical baseline for each person deployed is the same office that has in the past few years been recalcitrant to say the least in regard to providing information regarding Project 112 and the subsidiary experiments know as "SHAD" or "Shipboard Hazards And Decontamination." The actions regarding release of information regarding earlier exposures do not foster confidence or credibility that this operation is really concerned about the health of individuals who may have been harmed. As an example, there has been no access granted to any researcher to the blood serum repository located in Rockville, Maryland that DoD claims meets the requirement in regard to the blood sample. DoD knows, as does VA that there are tests for some of the potential harmful agents that can be applied to whole blood that cannot be applied to blood serum, yet they maintain that this is all that is needed.

What To Do Now

VVA would recommend that the Congress take several steps at this late date:

One, that you and your distinguished colleagues on the Armed Services Committee work directly with Secretary Rumsfeld to ensure that a system is put in place immediately that would ensure compliance with the pre-deployment physicals.

Two, that the Congress ensure that proper physicals, including a complete psycho-social exam and significant blood samples be taken in post deployment physicals on every returning service member.

Three, that Congress look into potential studies that have not been done in the past on existing samples that can be done for all Gulf War veterans, past and present.

Four, that VA "Fourth Mission" be properly funded, whatever the method of channeling funds to this purpose.

Five, that the War Related Injury and Illness Study Center (WRIISC) be greatly expanded and have a role in the implementation of military history for every veteran seeking medical help at VA. Further, VVA recommends that these centers be expanded, publicized, and much more closely linked with VA entities such as the Centers of Excellence in SCI, hepatitis C, and the National Center for Post Traumatic Stress Recovery.

Mr. Chairman, that concludes our statement. I would be pleased to answer any questions you may have.

VIETNAM VETERANS OF AMERICA
Funding Statement

March 27, 2003

A national organization, Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true for the previous two fiscal years.

For Further Information, contact:

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Richard F. Weidman

Rick Weidman serves as Director of Government Relations of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam War, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

Weidman was part of the staff of VVA from 1979-1987, serving variously as Membership Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of New York Governor Mario M. Cuomo as statewide director of Veterans Employment & Training (State Veterans Programs Administrator) for the New York State Department of Labor.

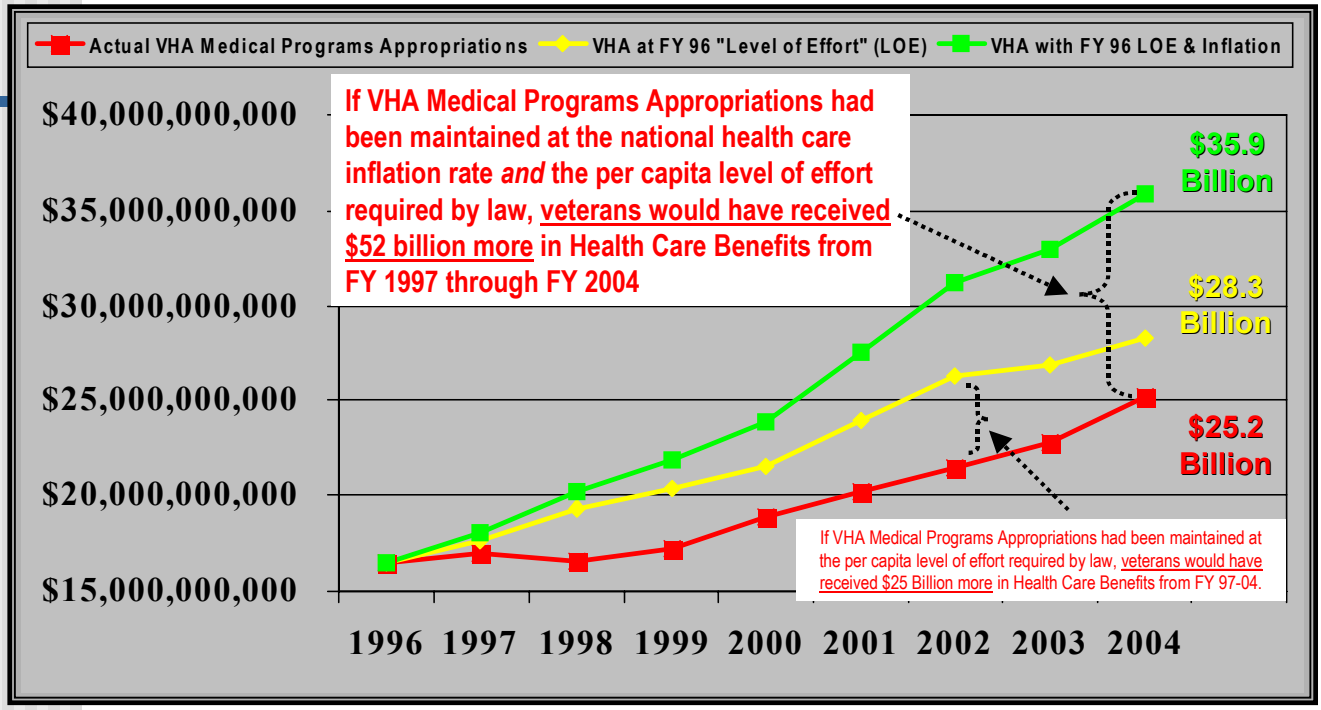
He has served as consultant on legislative affairs to the National Coalition for Homeless Veterans and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities Subcommittee on Disabled Veterans, the Advisory Committee on Veterans' Entrepreneurship at the Small Business Administration, and numerous other advocacy posts in veterans affairs. Among his other responsibilities, he is currently serving as Chairman of the Task Force for Veterans' Entrepreneurship and the Task Force for Veterans Preference & Government Accountability, both of which are mechanisms for veterans organizations and other Americans committed to justice for veterans to coordinate efforts on these vital issues.

Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he also was active in community and veterans affairs. He attended Colgate University, from which he received his bachelor of arts degree in 1967, and did graduate study at the University of Vermont.

He is married and has four children.

Appendix I

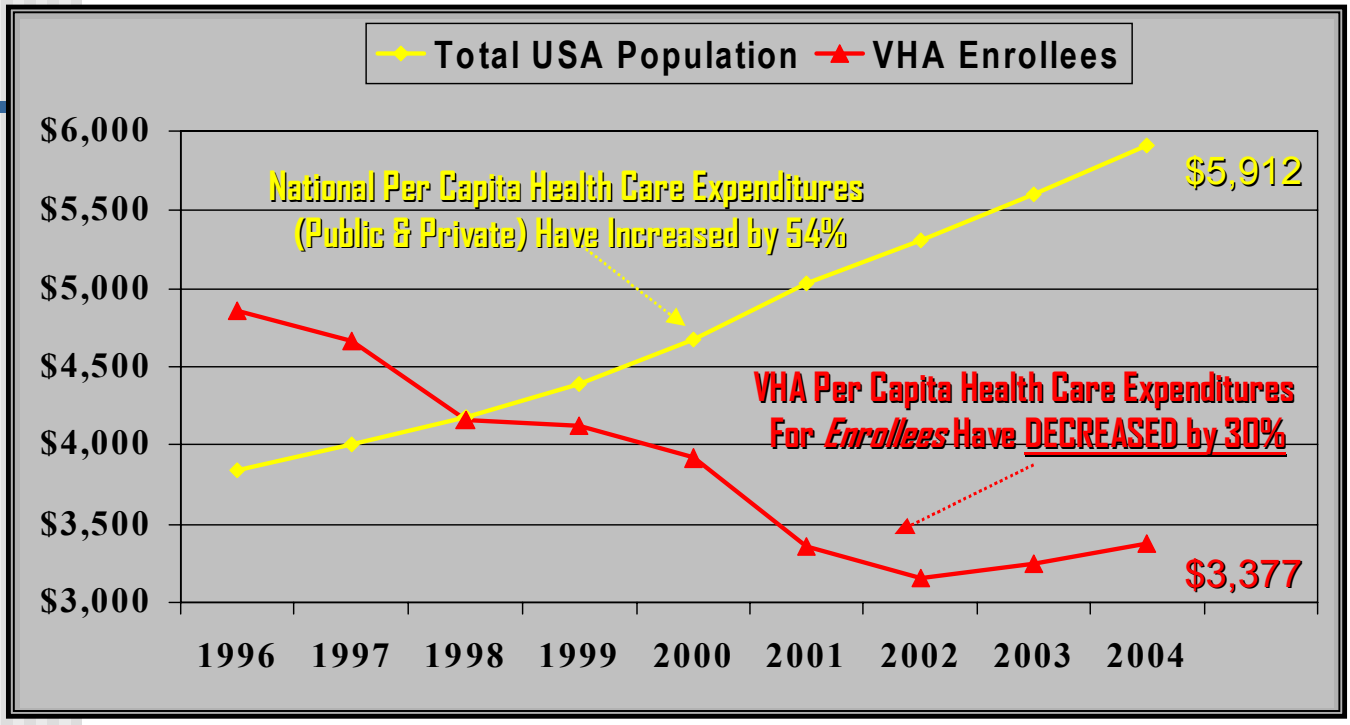
VHA Medical Programs "Should Spend" Budget



Sources: ***(VHA Medical Program Appropriations)*** - VHA Appropriations history/projections were e-mailed from the Veteran's Administrations Central Office (VACO) on 2-04-03. ***(VHA at FY 96 "Level of Effort" Budget Line)*** - Data derived by multiplying the FY 96 Per Capita "Level of Effort" ($5,633) by the number of VHA Users. FY 96-98 VHA Users are a VVA estimate. FY 99-04 VHA Users came from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04.
(VHA at FY 96 LOE & Inflation Budget Line) – Health care inflation figures for each FY were faxed to VVA from the Centers for Medicare and Medicaid Services (CMS) Actuarial Offices, and can be viewed for 1998-2004 at www.cms.gov/statistics/nhe/projections-2002/t1.asp. The CMS data are conservative because they do not reflect price inelasticity accounted for in the slightly higher health care inflation figures of the Consumer Price Index (patients cannot as easily substitute lower cost drugs/treatments as in other sectors).

Appendix II

Annual Per Capita Health Care Expenditures



Sources: ***(National Health Care)*** **-** Per Capita Expenditures are derived from the Centers for Medicare and Medicaid Services data found at http://www.cms.gov/statistics/nhe/, the "nhegdp01.zip" file (2nd table at bottom of web page). Projections for FY 02-04 are based on the average 5.5% per capita growth rate from FY 96-01.
(VHA) **-** Enrollee Per Capita Expenditures are derived by dividing FY 96-04 VHA Appropriations by the number of VHA enrollees. FY 96-98 are estimates based on the 16% enrollee/user difference in FY 99. FY 99-04 actual and projected enrollees are from the VHA Policy and Forecasting Office and utilize the "full demand" figures for FY 03 and 04. VHA Appropriations history and projections were e-mailed to VVA from the Veterans Administration Central Office (VACO) on 2-04-03.

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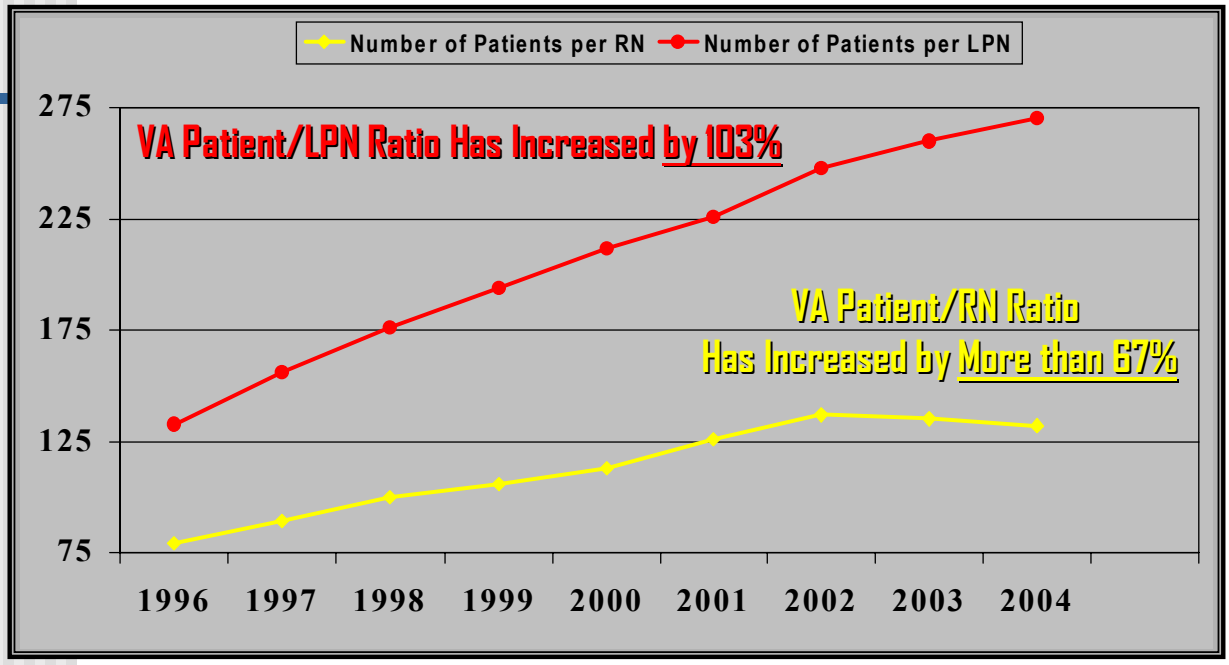
Appendix III

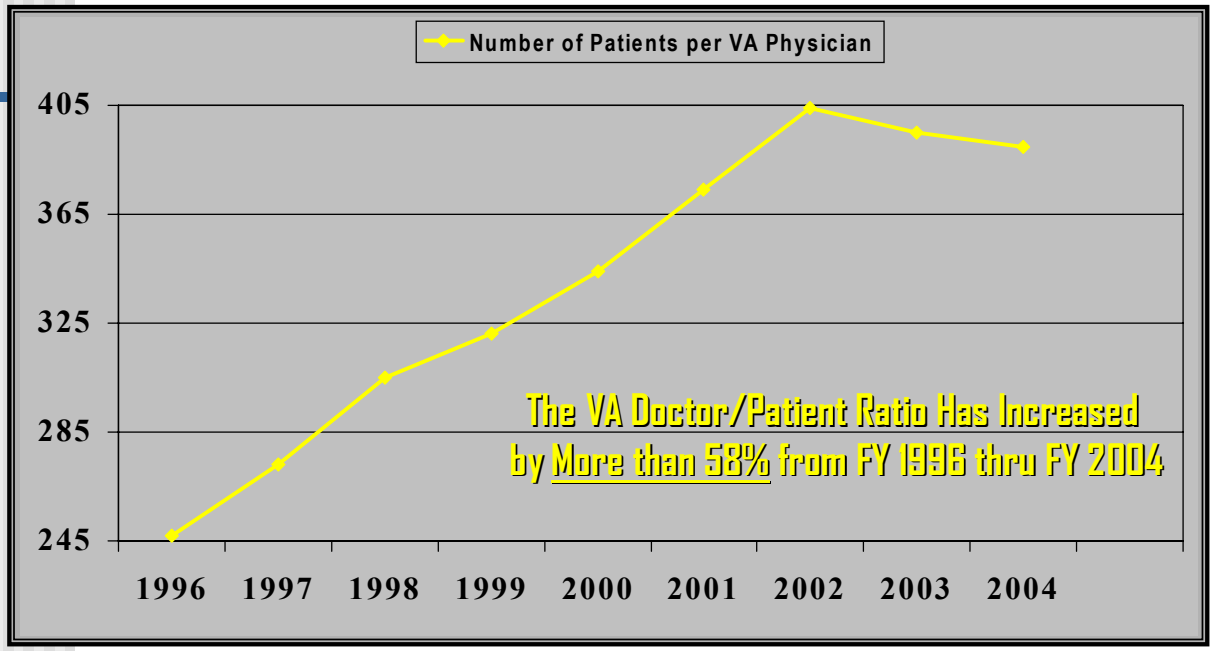
VA Nurse/Patient Ratio



Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03.

Appendix IV

VA Doctor/Patient Ratio



Source: Department of Veteran Affairs Forecasting and Policy Office Fax on 3-13-03.

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Appendix V

National Defense Authorization Act for Fiscal Year 1998''.

Public Law 105–85—Nov. 18, 1997

SEC. 765. IMPROVED MEDICAL TRACKING SYSTEM FOR MEMBERS DEPLOYED OVERSEAS IN CONTINGENCY OR COMBAT OPERATIONS.

(a) SYSTEM REQUIRED.—(1) Chapter 55 of title 10, United States Code, is amended by inserting after section 1074e (as added by section 764) the following new section:

''§ 1074f. Medical tracking system for members deployed overseas

''(a) SYSTEM REQUIRED.—The Secretary of Defense shall establish a system to assess the medical condition of members of the armed forces (including members of the reserve components) who are deployed outside the United States or its territories or possessions as part of a contingency operation (including a humanitarian operation, peacekeeping operation, or similar operation) or combat operation.

''(b) ELEMENTS OF SYSTEM.—The system described in subsection (a) shall include the use of predeployment medical examinations and postdeployment medical examinations (including an assessment of mental health and the drawing of blood samples) to accurately record the medical condition of members before their deployment and any changes in their medical condition during the course of their deployment. The postdeployment examination shall be conducted when the member is redeployed or otherwise leaves an area in which the system is in operation (or as soon as possible thereafter).

''(c) RECORDKEEPING.—The results of all medical examinations conducted under the system, records of all health care services (including immunizations) received by members described in subsection (a) in anticipation of their deployment or during the course of their deployment, and records of events occurring in the deployment area that may affect the health of such members shall be retained and maintained in a centralized location to improve future access to the records.

''(d) QUALITY ASSURANCE.—The Secretary of Defense shall establish a quality assurance program to evaluate the success of the system in ensuring that members described in subsection (a) receive predeployment medical examinations and postdeployment medical examinations and that the recordkeeping requirements with respect to the system are met.''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1074e (as added by section 764) the following new item:

''1074f. Medical tracking system for members deployed overseas.''.

(b) REPORT.—Not later than March 1, 1998, the Secretary of Defense shall submit to Congress an analysis of the administrative implications of establishing and administering the medical tracking system required by section 1074f of title 10, United States Code, as added by subsection (a). The report shall include, for fiscal year 1999 and the 5 successive fiscal years, a separate analysis and specification of the projected costs and operational considerations for each of the following required aspects of the system:

(1) Predeployment medical examinations.
(2) Postdeployment medical examinations.
(3) Recordkeeping.